



Massachusetts Neuropsychological Society



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April 4, 2014

Stuart Altman, PhD

Chair, The Commonwealth of Massachusetts Health Policy Commission

Dear Dr. Altman and other members of the Commission,

Thank you for the opportunity to comment on the Health Policy Commission's proposals for certification criteria for Patient-Centered Medical Homes. As President of the Massachusetts Neuropsychological Society (MNS), (www.massneuropsychology.org), I am providing comments on behalf of our organization and its members. MNS is the largest statewide professional organization of neuropsychologists in the country.

Brief Description of Clinical Neuropsychology (Our comments follow, below.)

Neuropsychologists are healthcare providers who are licensed as psychologists and hold doctoral degrees. They work at the intersection of medical and behavioral healthcare and treat people with neurologic, behavioral, neurodevelopmental, and other medical conditions. Using evidence-based tests, they assess, diagnose, and treat cognitive and emotional symptoms that are caused by behavioral health or physical health conditions, such as stroke, diabetes, depression, or schizophrenia. Additionally, neuropsychologists identify and treat emotional and cognitive factors that limit patients' adherence to medical treatment plans. They also direct prevention and wellness interventions that maintain cognitive health.

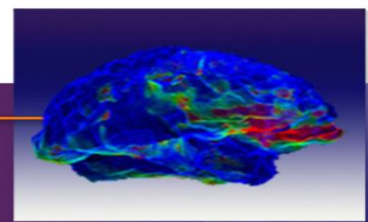
Neuropsychologists are particularly well suited to work in integrated healthcare models and to advance the triple aim of healthcare reform – efficient, cost-effective delivery of quality healthcare that results in better health outcomes for patients. They are well established as members of interdisciplinary treatment teams. Their biopsychosocial expertise is rooted in the science of brain-behavior relationships and gives the treatment team an integrated understanding of patients' healthcare needs.

Your questions:

1. Do the proposed criteria address expectations for patient-centered, value-based primary care?

We offer three comments in response to Question #1:

(1) We commend and thank the Health Policy Commission for addressing behavioral health needs so well with a streamlined process and focused criteria in the Definitions and Standards.



(2) In order to achieve the **Standards of Enhanced Access & Communication and Integrated Clinical Care (focus on behavioral health)**, we recommend the following. **Definitions**, which cite “access to appropriate care” (**Enhanced Access Standard**) and “align resources with population need” (**Integrated Clinical Care Standard**), should include: “Networks of behavioral health care clinicians must include the full range of licensed professionals, (such as doctoral level psychologists/neuropsychologists, medical doctors, and masters level behavioral health clinicians). These networks must also include clinicians working in solo or group practices (along with those working in larger healthcare organizations).”

Rationale: **a.** Different disciplines offer unique types of care, that are needed to meet different and specific patient needs. Primary Care Practices (PCPs) are not uniform in their knowledge of and use of different types of behavioral health clinicians. Specifying access to the full range of licensed professionals will ensure access to appropriately targeted and effective care. **b.** The volume of patients needing behavioral healthcare throughout Massachusetts necessitates access to clinicians working in a variety of settings. In some parts of the state, this problem is especially great because of geographic disparities in available clinicians. For example, in western Massachusetts and parts of central Massachusetts, some patients wait for up to a year for an appointment or cannot find a clinician to meet their medically necessary needs.

(3) Standard of Integrated Clinical Care Management: We recommend that the second point under the **Basic** pathway; the second point under **Advanced**; and the first point under **Optimal** include “cognitive” for screening and referrals, and for comprehensive assessment, (along with behavioral health/substance use disorders screening and referrals and comprehensive assessment). Additionally, all three pathways should include use of evidence-based, objective measures administered for periodic, ongoing screening of cognitive, emotional, and behavioral functioning in order to monitor improvement or worsening of symptoms. Results of those measures greatly aid in ensuring effective and appropriately targeted care, and the patient’s ability to access that care.

Rationale: Understanding a patient’s cognitive functioning is essential in developing and implementing his/her care plan, especially among high risk patients and among those with chronic and complex care needs. These patients are at increased risk for cognitive impairment. When working with primary care, neuropsychologists (who specialize in integrated assessment of cognitive, emotional, and behavioral/lifestyle functions), quickly stratify patient needs and develop treatment plans that primary care providers then use to manage and coordinate care.

2. **Are the proposed criteria appropriately assigned to each level of the Pathway and do they reflect progressive levels of advanced primary care?**

We offer one comment on Question #2

Basic: Care Coordination should include referral/specialty care tracking and follow-up.

Rationale: Healthcare needs for some patients with chronic medical conditions, behavioral health conditions, or neurologic conditions cannot be met without specialty care or behavioral health care assessment and/or treatment. All PCP’s will need to make and track referrals for some patients to receive the medically necessary care to treat and manage those conditions in the most outcome-effective and cost-effective way possible.

A few selected examples to illustrate:

(a) Patients with chronic conditions such as diabetes, cardiovascular disease, and/or obesity place the greatest demands on the healthcare system. Behavioral health treatment is integral in prevention and optimal management of these conditions since lifestyle factors play a key role in treatment. These conditions greatly increase the risk of damage to the vascular system in the brain, resulting in high risk for cognitive deficits. Patients with cognitive impairments, such as memory loss, poor language skills, or trouble with planning, will have difficulty understanding and following through with their care plans. When present, depression also complicates treatment of these conditions as it can cause fatigue, reduced initiation, and/or forgetfulness, which interfere with follow through in treatment. When cognitive or mood symptoms are not identified and treated, the patient's health may worsen as he/she forgets to take medications, takes medications incorrectly, or misses appointments. Instead of achieving optimal health, these patients develop more serious and debilitating disease that compromises their health further, and that is more difficult and costly to manage

(b) A child with asthma and co-existing ADHD: The family needs a behavioral healthcare component to maximize asthma care by managing ADHD symptoms (such as poor planning, lack of follow-through and forgetfulness).

(c) An adult with early Alzheimer's disease is in need of multidisciplinary care that includes neuropsychology for tracking cognitive decline and treating the patient and family to help them manage cognitive, emotional, and behavioral changes as the disease progresses. These interventions allow the patient to live in the community as independently as possible for as long as possible, which enhances health and reduces costs such as long-term care in institutions like nursing homes.

(d) Patients who have had a stroke or a TBI (traumatic brain injury) that caused cognitive, emotional, or behavioral symptoms require initial and ongoing assessment and treatment by a neuropsychologist as they recover from the injury. This care guides the patient, family, and treatment team with a plan that the patient and family can follow, working toward a return to effective functioning, at the highest level of independence possible, thereby achieving better health and averting additional costs to the healthcare system.

3. **Are there any suggestions for additional or different high-value PCMH criteria for consideration?**

We offer two comments on Question #3

(1) Definition for the Standard of Integrated Clinical Care Management (focused in behavioral health), states: "focus on patients with chronic and complex case needs." This seems to overlook the opportunity to provide effective preventive and early intervention treatment of all patients with, or developing, chronic behavioral health and/or medical conditions. Early intervention will reduce costs in the long run. We recommend the **Definition** states: "Focus on patients with behavioral health symptoms (including cognitive and/or emotional symptoms), that might impede effective treatment and management of their conditions".

We also recommend revision of the final statement in the **Definition** to state: "Integrate behavioral health and substance use evaluation and treatment into comprehensive care management (rather than as stated: "diagnostic and treatment considerations" as this allows "wiggle room" to cut corners in addressing suspected or identified behavioral health and substance use needs)

(2) We recommend a statement in the **Standards** that funding for and access to quality behavioral healthcare must be available in all healthcare delivery and payment systems.

Rationale: We are gravely concerned about existing barriers to accessing behavioral healthcare, which will prevent meeting expectations for high-quality health outcomes and cost-effective care. **We are happy to provide you with more details and to work with you in addressing these barriers.** We are also concerned that when organizations try to contain costs, behavioral healthcare is at greater risk of being shortchanged, compared with other types of healthcare.

Current barriers include:

- (a) Behavioral health insurance systems are difficult to navigate and benefits are hard to access: PCP's are stymied by how complex and opaque these can be, especially (but not limited to), when behavioral health benefits are administered by a behavioral health carve-out company. Behavioral health providers struggle routinely with navigating these systems and obtaining approval and/or payment for medically necessary services for their patients.
- (b) Reimbursement rates for behavioral healthcare have been dropping to the point of threatening economic viability of providing this care, and making it increasingly difficult for patients to find clinicians, group practices, and hospitals to provide the needed care, especially when they use their private or public insurance. Many people in the Commonwealth cannot afford to pay for their needed behavioral health care out of pocket.
- (c) Behavioral health services are integral to addressing some medical conditions for some patients (such as those cited as examples in our answer to question #2), yet some insurance companies prohibit billing for behavioral health and/or neuropsychological assessment and treatment for medical conditions, and limit those services to behavioral health conditions only.
- (d) Some MassHealth plans actually limit psychologists to providing assessment services only, denying patients covered by those plans access to an entire field of behavioral health clinicians. Psychologists and neuropsychologists are especially well trained and well suited to provide evidence-based treatment to patients who have chronic or complex behavioral health, neurologic, and/or other medical conditions.

Thank you for considering our comments. Please contact me if you have any questions or if we can assist you in advancing access to quality healthcare across the Commonwealth.

With best regards,

Margaret Lanca, PhD

President, Massachusetts Neuropsychological Society

PHONE:

email:

